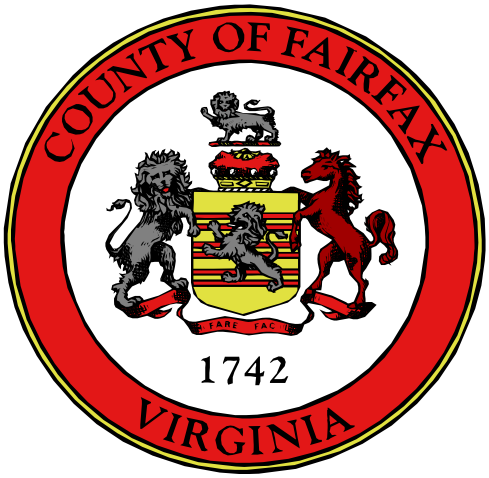
INTERNAL AUDIT REPORT

Audit of CMI Payments and Reimbursements



Fairfax County Internal Audit Office

FAIRFAX COUNTY, VIRGINIA
INTERNAL AUDIT OFFICE
MEMORANDUM

TO: Anthony H. Griffin
County Executive

DATE: January 27, 2003

FROM: Larry Hertzog, Acting Director
Internal Audit Office

SUBJECT: Report on the ***"Audit of CMI Payments and Reimbursements"***

Attached is the Internal Audit report entitled, ***"Audit of CMI Payments and Reimbursements."*** This audit was performed as part of our FY2002 Annual Audit Plan.

The findings and recommendations of this audit were discussed with the Department of Finance. We have reached agreement on all of the recommendations, and I will follow up periodically until implementation is complete. The department's responses are incorporated into the report and the full response is attached at the end of the report. After your review and approval, we will release the report to the Board of Supervisors.

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Attachment

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Introduction

Fairfax County retains the services of CompManagement, Inc. (CMI), a third-party claims management firm, to administer the County's self-insured coverage for Workers' Compensation and Automobile and General Liability. The County contracted with Trigon Administrators Inc. (Trigon) to provide this service in April 1998. Trigon was subsequently bought by CMI in April 2001. Trigon's contract with the County to provide third-party administrator (TPA) services for claims management and medical cost containment remained in effect with CMI. Responsibility for overseeing and monitoring CMI's performance rests with the County's Risk Management Division (RMD). RMD approves CMI's fund replenishment requests, processes recovery payments received, monitors transactions and calculation of fees, and is a primary contact between County customers and CMI.

The CMI claims operations unit in Chantilly handles claims from the time they are reported to CMI until they are successfully concluded. This unit investigates all claims, evaluates and reports to the County potential claim settlement opportunities, reviews and approves all medical bills, and sends the approved bills to the CMI regional office in Richmond for payment. The Richmond office handles all accounting and financial functions, and houses CMI's information systems technology resources.

The purpose for outsourcing claims management services to an outside organization specializing in this specific field is to take advantage of the organization's expertise and their efficiency arising from the economy of scale achieved by combining such services for many clients. As third-party administrator of the County's self-insured claims, CMI is expected to provide professional claims handling services in the review, investigation, processing, payment, recording and reporting of workers' compensation and liability claims, and the recovery of subrogation claims. (Subrogation claims are claims where the County may assume the legal right to collect damages in place of the injured party).

In addition, under the service contract, CMI is to provide a medical cost containment program offering contracted medical provider discounts, medical bill audits, and review procedures for reasonable and customary charges prevailing in various geographic areas. For the fiscal year ended June 30, 2002, cost containment savings for the County amounted to $761,380. Cost

containment savings is achieved by CMI through negotiation of discounts with service providers. During this same period, the County's expenditures totaled $5,498,537 for workers' compensation claims, and $1,328,873 for automobile and general liability claims, with recoveries on subrogation claims totaling $307,635. The total fee paid to CMI for their services was $653,112. RMD's FY 2003 Budget Plan projects funding for workers' compensation claims at $4.8 million, and for automobile and liability claims at 1.4 million.

Purpose and Scope

This audit of CMI was performed as part of our FY 2002 Long-Range Audit Plan. Our objectives were to determine that:

(1) payments made for workers' compensation, auto, and general liability claims are legitimate, fully supported by appropriate documentation, properly recorded, and in compliance with the terms of the service contract; (2) subrogation claim amounts are calculated accurately, claims are pursued aggressively, subrogation recovery payments are sent promptly to the Risk Management Division, and all payments received from CMI are recorded and deposited promptly by RMD in accordance with Accounting Technical Bulletin (ATB) 009; (3) the County's weekly reimbursements (through bank wire) for paid claims and the related cost containment fees are in accordance with the service contract, are supported, properly reviewed and approved by RMD, and correctly recorded on the County's Financial Accounting Management Information System (FAMIS); (4) CMI's fee billings for services rendered, are approved, justified, accurate, and in accordance with the service contract; and (5) any business practices pertaining to the third-party administrator's services are in compliance with the formal service agreement.

The scope of the audit included a review of claims processed and payments disbursed by CMI, as well as reimbursements to CMI made by the County. This audit was a high level examination of all major contract components. We reviewed selected samples of transactions, including claim reporting, claim processing, claim payment, the County's reimbursements to CMI, and fee billings from CMI. The audit period covered July 2001 through June 2002.

Methodology

We reviewed, analyzed and evaluated CMI's internal control procedures and the Risk Management Division's procedures for monitoring the performance of CMI. Our audit approach included interviewing appropriate employees and key CMI personnel, observation of employees' work functions, detailed testing of claims transactions/activities, and evaluating the processes for compliance with sound internal controls, internal policies and procedures, and government regulations. The samples examined during this audit were selected on a judgmental basis. Therefore, while the results may not be projected to reflect the entire volume of transaction activity, it does provide a measure of transaction accuracy, completeness, and exceptions. Where we noted opportunities for improvement, we brought them to management's attention.

Our audit did not include an examination of CMI's Workers' Compensation and Liability computer systems. The audit was performed in accordance with generally accepted government auditing standards. The Fairfax County Internal Audit Office is free from organizational impairments to independence in our reporting as defined by Government Auditing Standards. We report directly to and are accountable to the County Executive. Organizationally, we are outside the staff or line management function of the units that we audit. We report the results of our audits to the County Executive, the Board of Supervisors, and reports are available to the public.

Executive Summary

In our opinion, CompManagement, Inc. (CMI) is performing its services effectively and fulfilling its responsibilities in accordance with the third-party administrator contract. Internal controls are adequate, with a few exceptions, to ensure that payments made by CMI for workers' compensation, auto, and general liability claims are legitimate, fully supported by appropriate documentation, and properly recorded. CMI pursues subrogation claims aggressively, and sends recovery payments promptly to the Risk Management Division (RMD), although there were occasions when the subrogation claim amounts were not calculated accurately for some of the transactions reviewed. The County's weekly reimbursements (through bank wire) to CMI for paid claims and the related cost containment fees are in accordance with the service contract and correctly recorded on FAMIS. CMI also processes claims and refunds timely and accurately in accordance with law, the service contract and department policy, and utilizes all available discounts and cost containment programs. However, CMI's computer system did not identify duplicate invoices for a small number of worker's compensation claims in our sample, resulting in duplicated payments. In addition, CMI is taking steps to correct circumstances where bills have been approved for payment but were not entered on the system. CMI's fee billings for services rendered, are approved, justified, accurate, and in accordance with the contract.

The formal service agreement does not adequately describe certain significant business practices currently in effect pertaining to the third-party administrator's services. The funding arrangement for worker's compensation, automobile, and general liability claims should be described in writing, approved by both the County and CMI, and made part of the formal service contract. (Recommendation 1.1) In addition, RMD should draft written procedures, to be made part of the formal written agreement, regarding the handling of stale-dated checks, including each party's specific responsibilities for complying with the due diligence, reporting and escheat (transfer of unclaimed property to the state) requirements of the Unclaimed Property Act. (Recommendation 3.1) The contract also does not establish or define specific parameters over what is considered cost containment savings to be shared by the County and CMI for prescription drugs billed by Express Scripts. (Recommendation 14) It is our understanding that these arrangements, including a requirement for a SAS 70 audit to be performed annually by the third-party administrator, will be addressed in the upcoming contract negotiation.

Other recommendations that we rated "medium" or "low" priority are not summarized here but are described fully in the Comments and Recommendations section of this report.

Although there are advantages both at the expertise and the economy of scale levels to the outsourcing concept, the transfer of the claims service activities to an outside vendor represents not only cost to the County, but also has a direct bearing on the County's risk management decision-making process. It is important, therefore, that major claims activities be independently examined each year (perhaps focusing on the individual segments of claim processing in separate audits) until the County is assured that CMI has implemented all the audit recommendations for strengthening controls. In addition, RMD's monitoring of the third-party administrator should be intensified. This will ensure the services are being performed in the best interest of and at the lowest cost to the County, and are in agreement with the original intent and contractual arrangement. It will also allow management to determine the need for and the frequency of future audits.

This report has been discussed with the Department of Finance and the Risk Management Division. Management is in agreement with all recommendations.

Comments and Recommendations

1. The contract between the County and CMI does not contain a description of the funding arrangement for worker's compensation and liability claims. As of March 4, 2002, the fund balance carried on CMI's books exceeded the amount reflected on the County's general ledger by over $131,000.

The fund balance, referred to as the "desired balance" by CMI, represents the County's funding of the bank account used to pay its worker's compensation, automobile liability and general liability claims. The balance is reflected on the County's FAMIS general ledger under the account, "Cash with Fiscal Agent" (A/C #1030). The difference between the "desired balance" and the actual balance in the bank account is the amount requested by CMI to be replenished by the County each week. As of March 4, 2002, the total "desired balance" reported by CMI in their fund replenishment request was $318,163, whereas the amount recorded in the County's "Cash with Fiscal Agent" account was only $187,000, a difference of $131,164.

The terms of the service contract and the original County RFP contain no description of the funding arrangement, i.e., how the initial amount is determined and established, and how it is supposed to be increased or decreased. The service contract is the legally binding agreement between the County and its third-party administrator for the outsourced activities. The contractual specifications for performance and accountability reflect the County's requirements and provide the basis for measuring and monitoring the contractor's activities. Therefore, all important arrangements, particularly how the claim activities are to be funded, should be described in the contract in sufficient detail. The fund balance should also be correctly reflected on the County's books to enable the County to collect the proper amount of "Cash with Fiscal Agent" when the relationship with the agent ends.

Unless specifically provided for in the contract, CMI's current practice of increasing (or decreasing) the "desired balance" through their weekly replenishment requests, may or may not be approved by management in accordance with the County's original intent. Moreover, there is no guidance for monitoring the arrangement to determine whether the funding amount is appropriate in the light of existing conditions or prior experience. The monies returned to the

County upon termination of the relationship with the third-party administrator may not be the correct amount if the balance shown on the general ledger is incorrect.

CMI acknowledged that the funding arrangement was most likely just a verbal agreement between them and the previous County Risk Manager. RMD was not monitoring the funding practice and was unaware that the balance in the "Cash with Fiscal Agent" account differed from the "desired balance" shown on CMI's replenishment requests.

Recommendation 1 **High Priority**

RMD should determine if the current "desired balance" is the appropriate amount necessary to meet claim payments during the time period agreed upon with CMI. If RMD determines that the claim fund balance should be increased, it should increase the "Cash with Fiscal Agent" account balance on the books. If the "desired balance" currently held by CMI is determined to be excessive, CMI should "return" the overage to the County. In addition, the arrangement to set up a "desired balance" for the purpose of funding the claims account should be described in writing, approved by both RMD and CMI, and made part of the formal service contract.

Department Response

This recommendation was addressed through amendments to the contract, executed effective January 1, 2003. T**he desired balance has been reduced and remaining funds returned to the County Insurance fund.**

2. The Risk Management Division's (RMD's) procedures for handling subrogation recoveries and other payments received in the mail do not provide for proper accountability and adequate controls to safeguard the check payments prior to deposit. In addition, the checks are not being deposited within two business days from receipt as required by Accounting Technical Bulletin (ATB) 009.

One employee performs the tasks of picking up the mail containing check and money order payments from RMD's in-box, opening the mail, and removing the payment checks and letters from the envelopes. The same individual then distributes the checks and accompanying letters to the appropriate employees by placing them in folders marked with the respective employees'

names, and giving the folders to the Claims Manager for review. Throughout this process, only one individual has control over the assets; moreover, the checks are not listed in a record book to show how much was received and turned over to the Claims Manager. After reviewing the documents in the folders, the Claims Manager removes the checks and locks them up in her desk drawer. She then passes the file folders on to the responsible employees. Once a week, or once every 2 or 3 weeks (depending on the number of checks received), the Claims Manager removes the checks from her desk drawer and gives them to an administrative assistant who copies the checks, creates the appropriate accounting entries in FAMIS, obtains the Claims Manager's approval signature, and then takes the checks to the Department of Tax Administration for deposit.

There were 4 checks, totaling $16,155 that were deposited on April 8, 2002. Prior to that date, a deposit was made on March 29, consisting of 12 checks totaling $48,621. Of the 16 checks deposited on these two dates, six had not been stamped with the received date. The average time lag from receipt date to deposit date for the other 10 payments that had a "received date" stamp, was 14 days.

An objective of a good internal control system is to ensure that assets are adequately safeguarded from loss or theft. Controls to minimize exposure to such occurrences include dual control, separation of duties, and having a designated employee accountable for a specific sum of money. In addition, ATB 009 requires that checks received be deposited on the day of receipt or on the next business day, with the deposit being recorded to FAMIS within two business days.

The payments received through the mail could get lost or stolen and not be detected timely without adequate controls. Non-compliance with the requirements of ATB 009 for the prompt deposit of payment collections could result in failure to achieve RMD's and the County's objectives of improved cash flow and greater budgetary control.

Recommendation 2.1 High Priority

RMD should implement control procedures for handling recovery checks and other payments received in the mail to provide for proper accountability and safeguards over the check payments prior to deposit. Following are suggested procedures:

- All payments received should be date-stamped and recorded in a logbook indicating the date received, the type of payment, and amount.

- The mail should be under the dual control of two employees from the time it is received from the mail carrier up to the time the payments are recorded in the logbook. Both employees should initial the logbook after recording.

- The Claims Manager should also initial the logbook indicating her receipt of the checks when the payments are turned over to her.

Department Response

Recommendation 2.1 was implemented as suggested.

Recommendation 2.2 High Priority

The check collections should be deposited on the day of receipt or on the next business day as required by ATB 009.

RMD immediately implemented these recommendations as soon as they were brought to their attention during our audit. Therefore, no response is necessary.

3. The contract between the County and CMI does not describe each party's specific responsibilities over stale-dated checks drawn against the worker's compensation and liability claim fund accounts. Furthermore, there are stale-dated checks in the worker's compensation account that have long passed the timeframes required by law for escheating them to the state government.

The contract with CMI for third-party administrator (TPA) services does not specify each party's responsibilities over stale-dated checks. As of April 30, 2002, there were 30 checks, totaling $23,682, on CMI's list of outstanding worker's compensation checks that had been outstanding over 120 days. Seventeen of these checks, totaling $2,228 had been outstanding for over a year. No action has been taken on any of these old outstanding checks despite the legal requirements for due diligence, reporting, and escheat of such properties, with stiff penalties imposed for

noncompliance. There are potentially some stale-dated checks also in the County's automobile liability and general liability claim fund account. However, since the account is shared by the County with other clients of CMI, CMI does not prepare a bank reconciliation and outstanding checks report for each individual client. Therefore, we are unable to state the number and amount of stale-dated checks in the liability claim account.

Pursuant to the Virginia Uniform Disposition of Unclaimed Property Act (the Act), the State Treasury Department requires that, annually, all unclaimed properties (e.g., stale-dated checks) outstanding from June 30 of the previous year to June 30 of the current year must be reported and turned over to the state government by November 1 of the current year. Failure to do so will result in the imposition of penalties and interest prescribed in the Act. Penalties are also imposed for the non-issuance of due diligence letters to the payees or owners of the uncashed stale-dated checks. When certain actions are mandated by law to be followed for particular occurrences, it is imperative that the service contract spells out the specific responsibilities of each party for ensuring compliance with all requirements of the law.

The parties to the contract have no guidance on what action to take regarding stale-dated checks unless the specific responsibilities of each party are sufficiently described in the service contract. The lack of guidance could result in the County's noncompliance with the law and exposure to monetary loss due to the penalties and interest imposed for such noncompliance.

Recommendation 3.1 High Priority

RMD should develop written procedures on the handling of stale-dated checks, including each party's specific responsibilities for complying with the due diligence, reporting and escheat requirements of the Unclaimed Property Act. These procedures should be made part of the formal written agreement to ensure accountability and proper disposition.

Department Response

Risk Management tasked the County's Claims Third Party Administrator, CMI, to draft procedures on the handling of stale checks. These procedures were submitted to Risk Management in September 2002 and were implemented by CMI immediately. Procedures for

this process have been included in the new Request for Proposal for Claim Services, which will be effective July 1, 2003.

Recommendation 3.2 **Medium Priority**

RMD should request CMI to furnish the County with a quarterly outstanding checks report for the County's portion of the automobile and general liability bank account.

Department Response

Effective January 2003, Risk Management will begin to receive quarterly Stale Check reports for reconciliation purposes. Additionally a Stale Check report is produced and reviewed by CMI on a monthly basis.

Recommendation 3.3 **Medium Priority**

RMD should determine which of the stale-dated checks in the worker's compensation and liability bank accounts should be transferred to unclaimed property and escheated to the state government. RMD should consult with the Division of Unclaimed Property, Virginia Department of the Treasury, as to the amount of penalties and interest owed by the County, if any, as a result of the late reporting of the unclaimed property to the state.

Department Response

Risk Management will work with CMI to determine the most efficient handling of unclaimed property reports. By sharing CMI's due diligence efforts with the County, we might serve as an additional resource to locate the payees. Risk Management will work with the Department of Finance's Central Financial Services staff to develop procedures related to unclaimed property.

4. CMI's computer system failed to edit out duplicate invoices that were entered, resulting in duplicate payments (totaling $1,480) being made for three of the worker's compensation claims in our sample.

Three refund checks were sent in by providers on three different worker's compensation claims tested, due to duplicate payments made by CMI. Although the CPT (Current Procedural

Terminology) codes and service dates were the same on both the original and duplicate bills, the system edits failed to detect and reject the duplicates, resulting in the bills being paid twice.

Effective controls over disbursements require careful review of invoices by the adjusters prior to authorizing payment, and rigorous system edits to screen bills for duplicates, thereby avoiding costly overpayments to health providers. Duplicate payments could result in increasing the County's expenditures if the payees choose not to refund the overpayments.

CMI informed us that they process bills based on the information provided on standard industry forms, referred to as HCFA and UB92 forms, and billing statements. In the three cases of duplicate payments cited above, the physicians provided a HCFA form and a statement. The information on the statement did not capture all of the information on the HCFA form. Because of these differences, the system did not recognize it as a duplicate. CMI is currently requesting that all providers present medical claims in the HCFA and UB92 forms due to the increasing volume of statements received from providers and the potential for this type of problem reoccurring.

Recommendation 4 **High Priority**

RMD should follow up to see that providers present medical claims in the proper format.

Department Response

Recommendation 4 has been implemented. CMI procedures have been put in place requiring a standard reporting format, specifically HCFA and UB92. No payments will be made unless provided in this format.

5. Bills had been approved for payment but the payment was not entered on the system in two cases from our sample of twenty-five worker's compensation claims.

Two bills that had been approved for payment by CMI-Chantilly and stamped "Paid" by CMI-Richmond were not entered on the system and actually paid. In one case, the provider sent a tracer but it was rejected for payment as a duplicate invoice. The provider then sent past due

letters to the patient on April 15, May 11 and June 7, 2002 in an attempt to recover the outstanding unpaid amount. In the second case, the bill was never paid and no tracers were sent by the provider.

As third-party administrator of the County's self-insured claims, CMI is responsible for providing professional claims handling services, including the processing and payment of all legitimate bills from providers.

The health providers may resort to harassing the patients when their bills are not paid. Moreover, non-payment of claims could increase the County's potential exposure to legal challenges and create a poor image for the County.

According to CMI, this type of error occurred when a medical bill was entered on the system and held for payment. The payment was held because the medical payment was entered on a day set to produce vouchers. The payment was later released, then identified as an error and voided.

CMI has stated that the process of having a "voucher day" has been corrected. Their system can now produce vouchers and payments simultaneously, therefore eliminating the need to enter vouchers on a specified day. In addition, they have requested a report identifying "pended" payments to catch potential payment problems.

Recommendation 5 High Priority

RMD should follow up with CMI to determine that the control procedures described have been implemented.

Department Response

Risk Management will request that CMI provide copies of their control procedures and will confirm implementation of these.

6. CMI's worker's compensation system does not leave a transaction trail on the payment ledger screens when payments are moved from one claim account to another.

Two invoices from Virginia Medical Alliance, one for $84 and another for $192, were paid on April 5, 2002 and applied to claim account #646042-01-01-06, per CMI's replenishment reports dated April 8, 2002. However, only the payment for $84 appeared on the payment ledger screens (IPAY and IPMTS) for this account. There was no indication on the system ledgers or activity reports as to what happened to the payment of $192 for the second invoice. From discussions with the CMI adjuster who remembered what happened to the account, we learned that Virginia Medical Alliance's second invoice for $192 had been incorrectly posted to the account on 4/5/02, and the adjuster requested an adjustment on 4/16/02 to transfer the payment to another employee's claim account. The payment did get transferred, but in the process, the original transaction was deleted by the system from the first account, leaving no trail of what had happened. Furthermore, it was posted to the second account with an incorrect transaction date of 4/5/02. Although 4/5/02 may be the effective date, the adjustment transaction was not actually processed until after it was requested on 4/16/02.

Transaction trails, also known as information trails or audit trails, are a management control mechanism that enables the system users, executive management, and others responsible for the accuracy and completeness of processing, to verify information and reconstruct the processing of transactions. A sound financial system should, therefore, have the ability to retain all transaction information in the payment history ledgers, including a detailed chronology of the processing and any subsequent adjustments made to the original transaction.

Data integrity is lost when an individual can make changes to an account without a record of his/her actions being retained in the system's payment history screens. It would be difficult to verify information and reconstruct the processing of transactions unless the system routinely captures and retains all transaction activities in its payment ledger screens.

Recommendation 6 **High Priority**

RMD should request that CMI-Richmond ensure that their system includes a transaction trail mechanism that captures and retains transaction events in the payment history screens**.**

Department Response

Risk Management will request confirmation from CMI that their system includes a transaction trail mechanism.

7. On May 23, 2002, CMI's computer system incorrectly generated excessive cost containment fees that were charged to the County.

CMI collected a discount (or cost containment fee) on May 23, 2002 for six invoices in our sample of 10 payments that were made that day. The six invoice payments were subsequently voided on May 28, but the discounts paid to CMI, totaling $365, were not voided or refunded to the County. Furthermore, the Client Check Registers and check vouchers supporting CMI's replenishment request for disbursements made on May 23, showed 32 discount payments to CMI that had no basis since there were no bills paid to providers to justify the discounts. The total discount paid was $1,793.

A sound, reliable and accurate claim payment system should have the capability to recognize associated transactions in order to properly handle them when a change or adjustment is made to the main transaction. Therefore, CMI's system should have voided the associated discount payments when it voided the invoice payments that provided the source of the discounts. Likewise, the taking of a discount should be contingent on a payment being made on a provider's bill where the amount billed is greater than the amount paid.

If a discount payment is not voided when the related invoice payment is voided, the County is paying CMI for a cost containment saving that does not exist, thus needlessly incurring additional expenses. Moreover, discount payments to CMI that are not supported by medical providers' paid bills may be erroneous or improper.

According to CMI, the errors were caused by problems which occurred on May 23rd when they were undergoing a system conversion.

Recommendation 7.1 **High Priority**

RMD should request CMI to determine the reasons the system failed to void the associated discount payments and for taking discounts unsupported by medical bills, so that they can correct the problem.

Department Response

Risk Management will request the reasons for CMI's system failure involving discount payments, to include what mechanism has been put in place to prevent this future occurrence.

Recommendation 7.2 **Medium Priority**

RMD should ensure that the County is reimbursed for all the discounts that were erroneously paid to CMI and determine that CMI has taken appropriate measures to prevent reoccurrence of the errors, or at least allow early detection and correction of the errors should they occur.

Department Response

All reconciliations related to the system failure will be requested and Risk Management will ensure that all appropriate reimbursements are made to the County.

8. CMI took 100% of the cost containment savings for worker's compensation claims during the period of March 20 to 28, 2002, instead of only 25% as was the agreed procedure starting in January 2002.

In checking the cost containment discounts paid to CMI on our random sample of 25 worker's compensation claims, we found five accounts where CMI was paid a 100% discount on medical payments made from March 20 to 28, 2002. Because of a change in the discount-sharing calculation methodology implemented in January 2002, CMI was supposed to take only 25% of the cost containment savings, leaving 75% as the County's share. The County's 75% share for all claims during this 7-day period was $18,500.

CMI's contract with the County provides that cost containment savings will be shared at the rate of 25% to CMI and 75% to the County. This should be strictly adhered to regardless of the methodology used to calculate the share of each party. Prior to January 2002, CMI's procedure was to take 100% of the savings initially and then send a check at the end of each quarter to the County for its 75% share. The procedure was simplified starting January 2002, with CMI's system being programmed to take just 25% of the cost containment savings. The new procedure did not take effect for the County's claims until January 12, 2002 due to CMI system problems. Paying 100% of the cost containment savings to CMI after the switchover to the new calculation methodology could result in increasing the County's total expenditure on its worker's compensation claims.

According to CMI, its IT staff had inadvertently reversed the new procedure, causing the 25% to be changed back to 100%, during the period from March 20 to 28, 2002. CMI later corrected this by changing the percentage and providing a check to the County to cover the 75% of savings which were incorrectly taken. CMI has informed us that in the future, changes in the client data set-up will only be done with a Client Data Sheet modification to prevent a similar error from occurring again. In addition, their Client Accounting section will review the daily submission of payments to assure that the correct percentage is in place.

Recommendation 8 — Medium Priority

RMD should follow up with CMI to determine that these controls and corrective measures have been implemented and are functioning as intended.

Department Response

CMI has confirmed that changes to the client data set-up have been implemented to prevent similar errors from occurring again. CMI's client accounting section shall review the daily payment submissions to ensure that the correct percentage is in place. Written confirmation has been requested.

9. CMI does not deposit refund checks and post them to the worker's compensation system in a timely manner.

In our review of a random sample of 25 worker's compensation claims, there were two refund checks for $184 and $327, dated December 11, 2001 and February 12, 2002, respectively, that had not yet been deposited and posted to the system at the conclusion of audit fieldwork, July 30, 2002. Both checks were sent by the Fairfax Radiological Consultants to CMI-Richmond due to duplicate payments received on claims #646038-12-2001-3 and #646038-2-2001-6. A later examination of the system payment screens showed that the checks were finally posted to the appropriate claim accounts on August 6, 2002 after we had brought them to CMI's attention.

Effective financial management requires the prompt deposit and posting of payment checks to minimize the possibility of their getting lost or stolen and to improve cash flow. The potential risk of checks getting lost or stolen, or becoming "stale" and unacceptable to the bank, increases when they are not deposited and posted timely.

CMI-Richmond received the original refund checks from the medical provider, but could not process them for lack of important information details needed from the adjusters at CMI-Chantilly.

Recommendation 9 — Medium Priority

RMD should request CMI-Richmond to deposit and post refund checks promptly once they are received. CMI should set up a tracking system so that all information needed for posting the checks are requested from the appropriate adjusters in Chantilly and properly followed up to ensure timely posting and deposit. Alternatively, CMI could make copies of the refund checks when received, deposit the checks immediately, and post them to the system based on the check copies after they receive all required information details from CMI-Chantilly.

Department Response

Risk Management will request that CMI provide a response to this recommendation. Additionally, Risk Management will include this requirement in the new Request for Proposal for Claim Services, which will be effective July 1, 2003.

10. For eight claims in our sample of 14 worker's compensation subrogation claims (or 57%), the amount of the lien requested by CMI from the responsible party was incorrect, resulting in either higher or lower amounts than the actual losses incurred.

In four of the eight exceptions, CMI was calculating the cost containment fee portion of the lien by systematically taking 25% of the fees shown on the system (IPMTS screen). Actually, since January 12, 2002, the fees paid by the County to CMI that appear on the IPMTS screen have been 25% of the cost containment savings, reflecting the switchover in the fee calculation methodology from 100% to 25%. CMI, therefore, should not have applied another 25% against the fees that were paid after January 12, 2002 when calculating the amount to be recovered from the responsible parties. In the other four cases in our sample, there were no bills paid after January 12, but CMI had made clerical errors in calculating the lien amounts.

Third parties whose negligence causes the accidents involving county employees are liable for the damages that result. It is, therefore, imperative that CMI determine the actual losses incurred by the County and pursue recovery of the correct amounts from the responsible parties.

The calculation of the cost containment administrative fees by systematically applying 25% against the already 25% fees shown on the IPMTS screen results in a lower amount requested for reimbursement from the responsible parties. Other miscellaneous clerical errors could result in inaccurate lien amounts that may be either too much or too little, compared to the actual losses.

Lack of communication from CMI-Richmond to CMI-Chantilly caused the procedural issue of incorrectly calculating the 25% cost containment fee portion of the subrogation claim. Lack of a "quality control" review by both CMI-Chantilly and RMD allowed the clerical errors in the calculations of the lien amounts to go undetected and uncorrected.

Recommendation 10.1 **Medium Priority**

RMD should request CMI-Chantilly management to perform a quality control review of the adjusters' calculations of the subrogation lien amounts. Since RMD receives a copy of the

adjusters' subrogation claim requests, RMD should also review these and compare them to the amounts shown on the IPMTS screen for accuracy.

Department Response

Risk Management shall review and approve all calculations of subrogation lien amounts. A claims operating procedure will be developed. CMI will also provide a written quality control procedure to Risk Management.

Recommendation 10.2 Medium Priority

RMD should request that CMI-Chantilly correct the errors that were brought to their attention during the audit, review and correct other subro claims that have medical payments made in 2002, and adjust as necessary, the lien amounts they have requested for reimbursement from the responsible parties.

Department Response

Risk Management will request a written response from CMI to ensure that the errors have been corrected and that reimbursement is made to the County.

11. RMD does not review the accounting summary sheets supporting CMI's requests for replenishment of the funds used to pay worker's compensation and liability claims.

A review of CMI's accounting summary sheets and other documentation supporting their request for fund replenishment is not being performed by RMD prior to the wiring of the funds to CMI. This results in errors not being detected and corrected timely. Sound internal controls require a review process to identify errors and other unusual occurrences.

Recommendation 11 Medium Priority

RMD should review CMI's weekly request for the replenishment of the claim funds, reconcile it to the backup accounting summaries, and test-check the copies of the supporting check documents when these are received two days later. This review process would identify errors such as the excessive cost containment fees described in Comment 7, any unauthorized increases

in the "desired balance" (see Comment 1), as well as unusually large payments that may be questionable.

Department Response

Recommendation 11 has been implemented. Risk Management has implemented a weekly reconciliation of CMI's accounting summaries and is test checking the copies of the supporting check documentation. Risk Management is developing a claims operating procedure.

12. Four claims in our sample of 16 liability subrogation claims have accident dates between 10/27/97 and 10/9/01 but as of July 30, 2002, the responsible County departments had not submitted estimates of the damages to their vehicles to CMI.

For four claims in our sample of 16 liability subrogation claims, the departments involved, namely, Police, Public Works and Environmental Services (DPWES), and Sheriff's Department, had not submitted estimates of the damages to their vehicles to CMI as of the end of fieldwork, 7/30/02. The accident dates for these claims range from 10/27/97 to 11/13/01. CMI's status report to the Risk Management Division (RMD) on May 6, 2002 indicated that there were 21 outstanding liability subrogation claims, with accident dates between October 1997 and March 2002, for which CMI was still awaiting damage estimates in order to pursue subrogation recovery from the responsible parties.

RMD's Manual on Claims Reporting Procedures states that it is the department's responsibility to "ensure that all vehicles assigned to their department that are damaged due to an accident are estimated and repaired." The County's contract with CMI further states that "written notification of the County's intent to subrogate should be completed (by CMI) within 14 days following receipt of the claim. Upon determination of the actual damages, a demand letter shall be sent to the responsible party with follow-up at 30-day intervals."

Subrogation recoveries reduce the County's insurance losses. However, CMI is unable to pursue subrogation and demand reimbursement of property damages from the responsible party if it does not receive the damage estimates for the vehicles from the department.

The departments do not obtain repair estimates for various reasons, e.g., it is inconvenient, there is no other vehicle to use while their vehicle is being repaired, the vehicle still runs and the damage is not deemed a major one, etc. In addition, RMD does not consistently follow up with the departments to get timely estimates of the damages.

Recommendation 12 **Medium Priority**

When an accident occurs resulting in damages to a County vehicle, RMD should inform the agency involved immediately about the need to have the vehicle estimated and repaired promptly. Upon receipt of a status report from CMI about estimates still not received on outstanding subrogation claims, RMD should follow-up with the departments concerned for submission of the required estimates.

Department Response

Risk Management is developing a process to address this recommendation which will include requiring an agency to provide an estimate to Risk Management within a set timeframe.

13. The contract between the County and CMI does not establish or define specific parameters over what is considered cost containment savings to be shared by the County and CMI for prescription drugs billed by Express Scripts.

CMI uses the services of Express Scripts to pay the cost of prescription drugs. Express Scripts is a national company that has contracted with a variety of pharmaceutical firms to provide prescription drugs below retail cost. The pharmacies have agreed to the lower prices because of the purchase volume guaranteed them by Express Scripts at those prices. CMI does not pay a fee to Express Scripts for the latter's services. Instead, Express Scripts makes its profit from the business volume directed to them by CMI. Express Scripts bills CMI for the amounts it pays the pharmacies. CMI pays Express Scripts for the exact amount billed, yet CMI charges the County a cost containment fee equal to 25% of the difference between Express Scripts' billed amount and what would have been billed by the pharmacies directly. This arrangement is not spelled out in the contract which only states in general terms that CMI would provide a medical cost containment program that includes negotiated medical provider discounts (or cost containment savings) to be shared by CMI and the County.

As the legally binding agreement between the County and CMI, the service contract should describe in sufficient detail all important arrangements, including the use of an outside company for the payment of prescription drugs, what cost containment fee percentage should be collected by CMI, and how it is to be calculated under this special arrangement. Without specific parameters established in the written contract about what is considered cost containment savings in the payment of Express Scripts' bills and how CMI's percentage of the savings is to be calculated, it would appear that there is no contractual justification for CMI to charge the regular cost containment fee of 25% in this situation. CMI did not negotiate the discounts with the pharmacies, does not pay Express Scripts for the service, and simply pays the cost of the prescription drugs as billed to them by Express Scripts.

CMI had entered into the agreement with Express Scripts regarding the payment of prescription drugs without prior notification to RMD. RMD became aware of the arrangement only after the fact.

Recommendation 13 **Medium Priority**

The arrangement to use Express Scripts as the initial payer of prescription drugs to the pharmacies, the definition of the cost containment savings negotiated by CMI with Express Scripts and the percentage of the savings to be paid to CMI for this effort, should be described in writing and made part of the formal agreement.

Department Response

Recommendation 13 has been implemented. Effective January 1, 2003, the existing contract was amended to address this recommendation. Additionally, appropriate language has been included in the new Request for Proposal for Claim Services, which will be effective July 1, 2003.

14. Two of the 16 subrogation liability claims in our sample did not have a written notice to the citizen in the file folder, informing him or his insurance carrier that he was responsible for the accident and liable for any losses incurred.

The service contract with CMI requires that "written notification of the County's intent to subrogate should be completed (by CMI) within 14 days following receipt of the claim. Upon

determination of the actual damages, a demand letter shall be sent to the responsible party with follow-up at 30-day intervals."

It might be more difficult later on to obtain subrogation recoveries if a prior written notification of the County's intent to subrogate is not sent to the responsible party. The adjuster felt it was not necessary to send written notices as she had already discussed the cases verbally with the citizens involved.

Recommendation 14 **Low Priority**

RMD should request CMI-Chantilly to ensure that written notifications are sent promptly to the responsible party on subrogation claims as required by the service contract.

Department Response

Recommendation 14 has been implemented as suggested.

15. Recovery payments received by CMI are accumulated and sent to RMD once a week, regardless of the amount of the payment.

CMI normally accumulates the recovery payments it receives for a week before sending them to RMD. In our test sample of 16 subrogation liability claims, we noted one recovery check for $12,095 that took 8 days from receipt date before CMI sent it to RMD. Another check for $15,593 was held at CMI three days before its transmittal to RMD, while a third check for $390 was sent to RMD 14 days after it was received.

Effective financial management requires the prompt receipt and deposit of payments to improve cash flow and budgetary control.

The delayed receipt of recovery payments, particularly those of a sizeable amount, results in their delayed deposit with consequent "opportunity cost" to the County.

Recommendation 15 Low Priority

RMD should request CMI-Chantilly to send payments that are over a certain amount, e.g., $10,000, to RMD on the same day received. Payments below this cut-off amount may continue to be sent on a weekly basis.

Department Response

Risk Management will request that CMI send all payments over $10,000 to Risk Management on the same day received. Risk Management will develop a claims operating procedure.